

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155307		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2011	
NAME OF PROVIDER OR SUPPLIER TOWNE CENTRE HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/11/11</p> <p>Facility Number: 000204 Provider Number: 155307 AIM Number: 100284910</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</p> <p>At this Life Safety Code survey, Towne Centre Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This two story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and 1st floor resident sleeping rooms. The facility has a capacity of 120 and had a</p>			K0000	<p>Preparation and implementation of this plan of correction does not constitute admission or agreement by Towne Centre Health Care of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 7-11-2011. Towne Centre Health Care specifically reserves the rights to move to strike or exclude this document as evidence in any civil, administrative, and criminal action not related directly to the licensing and/or certification of this facility or provider.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0011 SS=E	<p>census of 89 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/14/11.</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sets of doors in the fire barrier separating the Health Care Center from the Independent Living occupancy provided the protection needed for a two hour fire barrier. LSC 19.1.1.4.2 refers to LSC 8.2. LSC 8.2.3.2.3.1 requires openings in a 2 hour fire barrier be provided with doors having at least a 1 1/2 hour fire protection rating. This deficient practice could affect visitors, staff and any resident on the 1st floor of the Health Care Center.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, the set of doors installed in a two hour fire separation wall between the Health Care Center and the</p>		K0011	<p>K011 1. The 1 ½ hour Fire rated doors have been ordered and will be in place by 8-10-11. 2. All residents have the potential to be effected. Correct fire rated doors will be installed. 3. Doors will be added to the preventative maintenance log and will be checked at least annually. 4. Maintenance staff will report findings from annual Door check to assure all doors meet code. Results will be reported to the QA committee for any recommendations for follow up. 5. Completed by 8-10-11.</p>		08/10/2011	

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K0014 SS=E	<p>Independent Living section had a one hour fire rating, less than the one and one half hour rating required for a door in a two hour fire wall. Based on interview at the time of observation, the Administrator and Maintenance Director acknowledged the door labels indicated the fire protection ratings for the doors were listed as 1 hour.</p> <p>3.1-19(b)</p>			K0014	<p>K014 1. Carpet has been removed. 2. All residents have the potential to be affected. Only proper flame spread rating material will be used. 3. Prior to any new products/decorating materials to be used on walls, partitions, columns and/or ceilings, proper flame spread rating will be verified by Administrator or other qualified professional. 4. The Administrator will provide a report of any new products/ materials to be used for decorating to the QA committee for any further recommendations. 5. Completed by 8-10-11.</p>		08/10/2011
	<p>Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2</p> <p>Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish for 4 of 8 corridors had a flame spread rating of Class A or Class B. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the</p>						

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	<p>flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect 40 of 89 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, there was carpeting covering portions of the first floor nurses' station located in the middle of the building at the center of four intersecting corridors. Interview with the Administrator and Maintenance Supervisor during the time of observation indicated documentation was not</p>						

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K0025 SS=E	<p>available to demonstrate the flame spread classification of the carpeting.</p> <p>3.1-19(b)</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through 2 of 7 smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect approximately 25 of 89 residents, staff and/or visitors using the corridors if smoke from a fire were to infiltrate the protective barriers.</p>		K0025	<p>K025 1. The penetrations in the smoke barrier walls identified above the D-hall and B-hall doors have been filled with proper fire rated material. 2. All residents have the potential to be affected. Penetrations in walls will be filled. 3. Upon any contractors performing work that requires penetrations in smoke barrier walls, Maintenance staff will follow immediately to fill any resulting penetrations. Monitoring for any other openings in a smoke barrier will be added to the monthly preventative maintenance log. 4. Results of monthly checks will be reported to the QA committee monthly until 100% compliance for 90 days. 5. Completed by 8-10-11.</p>		08/10/2011	

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K0048 SS=E	Findings include: Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, the first floor D hall smoke barrier had three penetrations of two or more inches in diameter around a group of pipes penetrating the smoke barrier wall which were not firestopped above the ceiling tile and the first floor B hall smoke barrier had a two inch penetration where a bundle of wires penetrated the smoke barrier wall which was not firestopped above the ceiling tile as well. Based on interview at the time of observation, the Maintenance Director acknowledged there were penetrations through the smoke barrier walls above the ceiling tile that were not smoke resistant. 3.1-19(b)						
	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on observation, record review and interview; the facility failed to provide an accurate written fire safety plan for the protection of 89 of 89 residents to accurately address fire extinguishers. This deficient practice could affect any of			K0048	K048 1. A,B,C Fire extinguishers have been purchased for each kitchenette. 2. All residents have the potential to be effected. Fire extinguishers will be present in areas identified in the facility Fire Plan. 3. The extinguishers will be added to the monthly preventative		08/10/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>the 89 residents, as well as staff, and visitors while in either dining room.</p> <p>Findings include:</p> <p>Based on review of the "Towne Centre Disaster Plan" with the Administrator on 07/11/11 during facility documentation review from 9:30 a.m. to 11:15 a.m., the fire action plan had a section covering the use of "A", "B", and "C" fire extinguishers and indicated a fire extinguisher was available in each holding kitchen. Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, neither the first or second floor holding kitchen was provided with a fire extinguisher. Based on interview at the time of observations, the Administrator and Maintenance Director acknowledged fire extinguishers were not provided in the holding kitchens.</p> <p>3-1.19(b)</p>				<p>maintenance log to assure extinguishers are in place and operational. 4. Maintenance staff will report the findings to the monthly QA committee for any additional recommendations. 5. Completed by 8-10-11.</p>		

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K0051 SS=F	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure fire alarm trouble signals were located in an area where it is likely to be heard as required by NFPA 72, 1-5.4.6. Additionally, NFPA 72, 1-5.4.6.1 requires visible and audible trouble signals and visible indication of their restoration to normal shall be indicated at the following locations:</p> <p>(1) Control unit (central equipment) for protected premises fire alarm systems</p> <p>(2) Building fire command center for emergency voice/alarm communications service</p> <p>(3) Central station or remote station location for systems installed in compliance with Chapter 5, 1-5.4.6.2</p>			K0051	<p>K051 1. The DACT device has been ordered and will be installed at the fire panels at the nurses stations. 2. All residents have the potential to be affected. Fire alarm trouble signals will be annunciated to the fire alarm panels at both nurses stations. 3. Audible and visible annunciation at the fire alarm panel and both nurses stations will be added to the monthly maintenance fire alarm test to assure proper operations. 4. Results of the monthly tests will be presented to the monthly QA Committee for review and any further recommendations. 5. Completed by 8-10-11.</p>		08/10/2011

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K0062 SS=C	This deficient practice could affect all occupants. Findings include: Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, the fire alarm control panel (FACP) and the Digital Alarm Communicator Transmitter (DACT) were located in the first floor mechanical room, an area remote from any area where continuous on site monitoring could occur, such as a nurses' station. The first and second floor nurse's stations each did have a fire alarm annunciator but the trouble signal from the DACT was not annunciated to the fire alarm panel or the annunciators located at the nurse's stations. The Administrator and Maintenance Director confirmed at the time of observation, the FACP and DACT was monitored off site but the onsite DACT audible trouble alarm would not likely be heard. 3.1-19(b)						
	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the			K0062	K062 1. The gages are being		08/10/2011

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	<p>facility failed to ensure 1 of 1 sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, the sprinkler system risers located in the first and second floor riser rooms had a pressure gauge with a date indicating the gauges were manufactured in 2005. Based on interview at the time of observation, the Maintenance Director indicated the gauges were replaced in 2008 but had no written documentation to verify the installation.</p> <p>3.1-19(b)</p>				<p>replaced. 2. All residents have the potential to be affected. Gages will be recalibrated or replaced every 5 years. 3. Documentation will be maintained to prove recalibration or replacement every 5 years. The 5 year schedule dates will be added to the Fire Drill documentation record book. 4. The QA committee will review the Fire Drill record book to assure the schedule is in place and completed as scheduled. 5. Completed by 8-10-11.</p>		

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K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect residents, staff and visitors in and near the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>Based on observation and interview with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, the only ventilation provided was by natural means with a vent pipe that extended through the roof.</p> <p>3.1-19(b)</p>			K0143	<p>K143 1. 1) The Mechanical Ventilation has been installed. 2) Signage has been added to the oxygen room door. 2. 1 & 2) All residents have the potential to be affected. Mechanical ventilation will be provided to oxygen storage rooms. Signage will be present to indicate that oxygen transferring is occurring. 3. 1) The mechanical venting system will be added to the monthly maintenance program to monitoring to assure vent continues to function properly. 2) Signage will be added to the weekly maintenance round sheet to assure signage is present for use. 4. Results of the weekly rounds for signage and monthly checks for the proper ventilation function will be presented to the monthly QA for 3 months until at least 95% compliance is maintained. 5. Completed by 8-10-11.</p>		08/10/2011

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K0144 SS=F	2. Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas were provided with signage indicating oxygen transferring is occurring. This deficient practice could affect residents, staff and visitors in and near the oxygen storage and transfilling room. Findings include: Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, the facility's oxygen storage and transfilling room was not provided with a sign indicating transferring of oxygen was occurring. Based on interview at the time of observation, the Administrator and Maintenance Director acknowledged the transferring of liquid oxygen does occur in the oxygen storage and transfilling room and the only sign provided was a warning for the presence of oxygen. 3.1-19(b)						
	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview for 12 of 12 months, the facility failed to		K0144	K144 1. A new form is being utilized to record the Monthly		08/10/2011	

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	<p>exercise the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Weekly Generator Test Log Sheet" and interview</p>				<p>Generator testing. 1) The amperage and the percentage of load capacity will be tested and recorded on the monthly form. 2) The length of time to transfer emergency power to the building will be recorded monthly on the new form. 3) A manual stop station has been ordered and will be installed upon arrival. 2. All residents have the potential to be affected. A new form will be implemented to assure proper testing is completed. A manual stop will provide ability to shut down the engine from a remote location. 3. 1,2) The new forms from the monthly Generator tests will be reviewed by the Towne Centre Executive Director and the Health Care Administrator upon completion of the monthly test. 3) The Manual remote stop device will be added to the monthly Preventative Maintenance program. 4. Results of tests will be presented to the monthly QA ongoing for any further recommendations. 5. Completed by 8-10-11.</p>		

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	<p>with the Maintenance Director on 07/11/11 during facility documentation review from 9:30 a.m. to 11:15 a.m., the generator was run under load on a monthly basis but the amperage was not recorded and the percentage of load capacity was not recorded.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of electrical power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Weekly Generator Test Log Sheet" and interview with the Maintenance Director on</p>						

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	<p>07/11/11 during facility documentation review from 9:30 a.m. to 11:15 a.m., monthly load tests are documented on the weekly test log but the time to transfer building power to the emergency generator was not documented. Based on interview at the time of record review, the Maintenance Director was not sure what the length of time to transfer building power to the emergency generator was.</p> <p>3.1-19(b)</p> <p>3. Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a</p>						

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K0147 SS=E	remote location. This deficient practice could affect all occupants in the facility. Findings include: Based on observation with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, evidence of a remote shut off device was not found for the generator. Additionally, based on interview and review of the generator nameplate, the Administrator and Maintenance Director indicated the 230 KW generator with 172 horsepower was installed originally with the facility in 1987. 3.1-19(b)						
	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 15 wet location resident care areas were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas that are subject to wet conditions while patients are present.			K0147	K147 1. A GFCI receptacle has been installed near the second floor clean utility sink. 2. The room is locked with key pad entry so only staff have access to be affected. It is possible that any other staff, visitors or residents in the vicinity of the second floor utility room could be affected. GFCI breakers will be installed where required. 3. An audit of		08/10/2011

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	<p>These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any resident, staff or visitor in the vicinity of the second floor clean utility room.</p> <p>Findings include:</p> <p>Based on observation and interview with the Administrator and Maintenance Director during the tour from 11:30 a.m. to 2:00 p.m. on 07/11/11, an electric receptacle was on the wall within three feet of the second floor clean utility sink. Based on interview with the Maintenance Supervisor at the time of observation, neither the electrical outlet nor the circuit breaker for this outlet was provided with GFCI protection.</p> <p>3.1-19(b)</p>				<p>other wet areas to determine proper GFCI receptacles are present will be conducted and completed by Health Care Administrator and Maintenance staff or other qualified professional will provide necessary replacement of receptacles as necessary. The Towne Centre Executive Director will monitor completion of installation to assure compliance is attained. 4. The Towne Centre Executive Director will report compliance results to the following QA committee meeting until 100% compliance is attained. 5. Completed by 8-10-11.</p>		

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K0154 SS=C	<p>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. in order to protect 89 of 89 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. NFPA 25, A-11-5(c)2 states, "a fire watch should consist of trained personnel who continuously patrol the effected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the</p>			K0154	<p>K154 1. The Disaster Plan has been updated to include the amendments to the Fire Watch procedure including what action to be taken in the event of a sprinkler system impairment and to include notification of any outage for more than 4 hours to the ISDH. 2. All residents have the potential to be affected. The Disaster Plan will be revised. 3. The Health Care Administrator will in-service the Towne Centre Executive Director and the Maintenance department staff of the revised fire watch procedure once approved by the QA committee. 4. The Health Care Administrator will present revisions to the Disaster Plan regarding the Fire Watch changes to the QA Committee for approval. The Maintenance Supervisor will present results of any Fire Watch performed to the QA Committee for evaluation of the event and to make any further recommendations. This process will be on-going. The HC Administrator will present details of any reports of outage lasting more than 4 hours that resulted in report of unusual occurrence to the ISDH to the QA Committee</p>		08/10/2011

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	<p>other fire protection features of the building such as egress routes and alarm systems are available and functioning properly." This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Towne Centre Disaster Plan" with the Administrator on 07/11/11 during facility documentation review from 9:30 a.m. to 11:15 a.m., the "Building Designs and Safety Features" section, # 5 stated, "When the fire alarm system is out of service for more than <u>4 hours</u> in a <u>24 hour</u> period, the Fire Department must be notified by the person in charge of the building. A fire watch must be implemented to protect all parties left unprotected by the Fire Alarm shut down until the Fire Alarm System has been returned to service. (See Fire Watch Procedures). Based on interview at the time of review, the Administrator acknowledged the statement did not address all components of LSC Section 9.7.6.1. Specifically, the statement did not include action to be taken in the event of a sprinkler system impairment and did not include notification of the outage to the Indiana State Department of Health.</p> <p>3.1-19(b)</p>				for further review and recommendations. 5. Completed by 8-10-11.		

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K0155 SS=C	<p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure its written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. in order to protect 89 of 89 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Towne Centre Disaster Plan" with the Administrator on 07/11/11 during facility documentation review from 9:30 a.m. to 11:15 a.m., the "Building Designs and Safety Features" section, # 5 stated, "When the fire alarm system is out of service for more than <u>4 hours</u> in a <u>24 hour</u> period, the Fire Department must be notified by the person in charge of the building. A fire watch must be implemented to protect all parties left unprotected by the Fire Alarm shut down until the Fire Alarm System</p>		K0155	<p>K155 1. The Disaster Plan has been updated to include the amendments to the Fire Watch procedure to include notification of any outage for more than 4 hours to the ISDH. 2. All residents have the potential to be affected. The Disaster Plan will be revised. 3. The Health Care Administrator will in-service the Towne Centre Executive Director and the Maintenance department staff of the revised fire watch procedure once approved by the QA committee. 4. The Health Care Administrator will present revisions to the Disaster Plan regarding the Fire Watch changes to the QA Committee for approval. The HC Administrator will present details of any reports of outage lasting more than 4 hours that resulted in report of unusual occurrence to the ISDH to the QA Committee for further review and recommendations. 5. Completed by 8-10-11.</p>		08/10/2011	

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	has been returned to service. (See Fire Watch Procedures). Based on interview at the time of review, the Administrator acknowledged the statement did not address all components of LSC Section 9.6.1.8. Specifically, the statement did not include notification of the outage to the Indiana State Department of Health. 3.1-19(b)						